2013 WL 4833751 (Ariz.Super.) (Trial Motion, Memorandum and Affidavit)
Superior Court of Arizona.
Maricopa County

Alberto GARCIA and Audrey Dupee, Husband and Wife, Plaintiffs,
v.
VHS ACQUISITION CORPORATION dba/aka and Maryvale Hospital Abrazo Health Care Inc. dba/aka Maryvale Hospital Vanguard Health Management, Inc. dba Maryvale Hospital; Hospital Development of West Phoenix, Inc. dba Maryvale Hospital John Does and Jane Does 1-10 ABC Corporations 1-10 XYZ Partnerships 1-10, Defendants.

No. CV2010-070091.
June 17, 2013.

MHMC's Trial Memorandum on the Adult Protective Services Act and Objection to Plaintiffs' Request for an APSA Jury Instruction

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Honorable Michael Gordon.

Defendants VHS Acquisition Corporation dba/aka Maryvale Hospital; Abrazo Health Care, Inc. dba/aka Maryvale Hospital; Vanguard Health Management, Inc. dba Maryvale Hospital, and Hospital Development of West Phoenix, Inc. dba Maryvale Hospital (hereinafter MHMC), hereby submits its trial memorandum regarding the inapplicability of the Arizona Adult Protective Services Act (APSA) to acute care hospitals such as Maryvale Hospital and in support of its objection to the giving of a jury instruction on APSA. MHMC files this Trial Memorandum with the Court to inform the Court on the current state of the law on APSA with respect to its application to an acute care hospital such as Maryvale Hospital. MHMC also respectfully asks this Court reject Plaintiffs' request for a jury instruction on APSA because: (1) the Legislature never intended APSA to apply to acute care hospitals: and (2) Plaintiffs have not made *a prima facie* case that would allow the Court to read an APSA instruction even if it applied. [1]

I. APSA DOES NOT APPLY TO ACUTE-CARE HOSPITALS

APSA's *enumerated* facilities are "a nursing care institution, an assisted living center. an assisted living facility, an assisted living home, an adult day health care facility, a residential care institution, an adult care home, a skilled nursing facility or a nursing facility." A.R.S. §46-455(B)(1). Acute-care hospitals (and hospitals in general) are notably absent from this list. MHMC, an acute-care hospital, does not fall into the definition of any of the facilities listed in the APSA. [2]

Acute care hospitals are the largest, most regulated and the most recognizable medical facilities available to the public in terms of health care. Acute care facilities provide medical care and treatment for major illness, injury, joint replacement, and trauma. They do so by using state of the art operating rooms, state of the art radiology (CT scans, MRIs, ultrasound, etc...). heart catheterization labs. neurology labs, pathology labs, and access to specialists. None of this is available in the facilities listed in the APSA. This alone makes them distinguishable from the facilities listed in the APSA in both scope and purpose. It also makes the only plausible reason that the Legislature did not include acute care hospitals in the list of facilities covered by the APSA, because the Legislature never intended for the APSA to apply to them.

A. The term "provide care" is vague in the context in which it is used in APSA and must be interpreted consistent with the purpose and scope of APSA.

APSA states:

> A vulnerable adult whose life or health is being or has been endangered or injured by neglect, **abuse** or exploitation may file an action in superior court against any person or enterprise that has been employed to *provide care,* that has assumed a legal duty to *provide care* or that has been appointed by a court to *provide care* to such vulnerable adult for having caused or permitted such conduct.

A.R.S. § 46-455(B) (*emphasis* added).

Because APSA does not define the term "provide care" and does not list acute care hospitals in its list of covered facilities, the term "provide care" is vague in the context of whether the Legislature meant for the APSA to apply to acute care hospitals. The goal in construing a statute is "to fulfill the intent of the legislature that wrote it," but when the statute's language is vague. legislative intent is determined by, "reading the statute as a whole, giving meaningful operation to all of its provisions, and by considering factors such as that statute's context, subject matter. historical background, effects and consequences, spirit and purpose." Zamora v. Reinstein, 185 Ariz. 272, 275; 915 P.2d 1227, 1230 (1996).

The term "provide care," which is a modifying clause used to limit who is subject to an APSA claim, is ambiguous and requires interpretation; otherwise, persons that are not listed as specifically exempt from the statute and who provide any type of aid or attention to a vulnerable adult would be subject to suit which could lead to some very unintended consequences.

First, without interpretation, applying "provide care" results in absurdity. Second, the "provide care" language needs to be interpreted within the context of the statutory language declaring the institutions that are amenable to APSA claims. Third, Plaintiff completely ignores the language in A.R.S. §46-455(C) that exempts providers of medical service who treat a vulnerable adult within two years of a decision to place the vulnerable adult in a listed facility.

If "provide care" is to be read literally without reasonable interpretation, without boundaries set consistent with the context of the facilities listed in the statute, then the scope of this statute has no bounds. As defined, the word "provide" when used as a transitive verb means, "to supply or make available (something wanted or needed) <provided new uniforms for the band>; also: afford <curtains provide privacy>." Merriam-Webster Online Dictionary, *www.merriam-webster.com/dictionary/provide.* The word "care" is defined as. "painstaking or watchful attention." *Id.* at *www.merriam-webster.com/dictionary/care.*

Under Plaintiffs logic, anyone who supplies watchful attention to a person covered under APSA may be sued absent an expressed exception. The person providing watchful attention need not even be aware that the person is a vulnerable adult defined by APSA. To illustrate:

1. A police officer who arrests someone over the age of 18 and puts that person in handcuffs in the back of a squad car is subject to APSA claims for any claimed negligence befalling the person in custody. The person in custody is certainly unable to protect himself thereby rendering him vulnerable and is definitely under the watchful attention being supplied by the officer.

2. A transport driver, without any medical training whatsoever, who transports a person that happens to fit the definition of vulnerable person would likewise be subject to a claim under APSA for any claimed negligence to provide "care" to the passenger in his charge.

3. A consulting specialist, such as a pulmonologist who sees a patient in the ICU of an acute care hospital, would be subject to APSA liability, but the same consulting pulmonologist who sees the same patient for the same medical issue in one of the facilities expressly listed in the APSA, would be immune from APSA liability.

It is unfathomable that the Legislature intended for this law to produce these results. To prevent such absurdities. the "provide care" modifier concerning who is subject to claims under APSA must be interpreted in some meaningful way so that the scope of this statutory regime does not leave its proper mooring.

APSA's well-documented legislative history reveals that the Legislature intended APSA to apply only to long-term care facilities, such as assisted living centers and adult care homes. This intent is consistent with certain other provisions in APSA. *Milner v. Colonial Trust Co.,* 198 Ariz. 24. 27; 6 P.3d 329, 332 (App. 2000) ("We look to statutes on the same subject matter or statutes that are part of the same statutory scheme to determine legislative intent and to maintain harmony."). Reading APSA to include application to acute-care hospitals, like MHMC, impermissibly violates the bedrock principles of statutory construction. *See Zamora,* 185 Ariz. 272, 275; 915 P.2d 1227, 1230 (statutes must be interpreted "in such a way as to achieve the general legislative goals that can be adduced from the body of legislation in question").

B. *Pre-McGill* legislative history reveals the Legislature's intent to limit APSA to long-term care facilities.

APSA was codified as A.R.S. §46-455(B) in 1989. *See* Ariz. Sess. Laws 1989, Ch. 118. § 1. The stated purpose was to "insure honesty in *long-term care*" in light of Arizona's "rapidly growing aging population" and the "thousands of people who are. or ought to be. in *licensed facilities.*" *See* Minutes of Human Resources and Aging Committee for HB 2437, 3/9/89 (Exhibit 1). The statute provided a "central depository of claims against *homes that house adults"* and allowed "current status reports for *adult care housing." Id.* It was intended to prescribe "actions for the restraint and remedying of violations by *adult health care providers." Id.* The Arizona Supreme Court recognized the limited scope of the original statute. "The legislature's intent and the policy behind the **elder abuse** statute are clear. Arizona has a substantial population of **elderly** people, and the legislature was concerned about ***elder abuse."*** *In re Denton,* 190 Ariz. 152, 156; 945 P.2d 1283, 1287 (1997) (emphasis added). *See also Estate ofMcGill v. Albrecht,* 203 Ariz. 525, 528; 57 P.3d 384, 387 (2002).

In 1998, the Legislature amended APSA. The amendments were enacted in conjunction with several other statutes to strengthen "*residential care facilities* licensing laws." *See* Ariz. Sees. Laws 1998, Ch. 161, §§5, 8; Arizona Senate Fact Sheet for SB 1050 (1998) (Exhibit 2). The Legislature was again concerned about **abuse**, neglect, and financial exploitation of adult residents of long-term care facilities, and specifically targeted "adult care homes, adult foster care homes, group homes, supervisory homes, supporting residential facilities. [and] nursing homes." *See* Minutes of Appropriations Committee for SB 1050, 4/21/98.[3] (Exhibit 3). The amendment followed the recommendations of a Joint Legislative Task Force on **Elderly Abuse**, which had been appointed "to investigate **abuses** of **elder** adults in Arizona's *adult care industry,"* and charged with addressing several issues related to the protection of the vulnerable adult population, including "the improvement of the regulatory licensing structure of *residential care facilities." Id.* As a result, the licensing statutes for residential care institutions, nursing care institutions, and home health agencies, were amended to require fingerprinting and criminal history records checks of owners. *Id.:* A.R.S. § 36-411 (A). These requirements were not extended to hospital licenses. *Id.*

C. The McGill decision supports MHMC's position.

In *McGill,* the Plaintiff sued two doctors under both the medical malpractice statute and the APSA. 203 Ariz. at 527; 57 P.3d at 386. The Court held that a single act of medical negligence could provide a basis for APSA action against licensed health care providers. *Id.* at 501; 57 P.3d at 390. The Court believed that this conclusion was consistent with the Legislature's intent in enacting APSA. *Id.* at 530-31; 57 P.3d at 389-90.

Even though the Court's extension of APSA to individual medical providers was later amended out of APSA by the Legislature, the Court's analysis in that case distinguishing APSA claims from non-APSA claims provides guidance in this case. In authoring *McGill,* Justice Feldman (retired) provided the following analogy to explain what is NOT covered by APSA:

> Consider for a moment the situation of a surgeon who, while operating on a patient, negligently fails to remove an instrument or discover a perforation in the viscera. Such negligence and the resulting injury can afflict anyone, not just the incapacitated, and is completely separate from the unique role of caregiver and incapacitated recipient. Thus, it would fall only within MMA, not APSA.

203 Ariz. 525, 529-30; 57 P.3d 384, 388-89 (2002). Why did Justice Feldman state that claims against the surgeon, or for that matter the hospital where the surgery took place, could not be brought under APSA? Short of being dead, can a human being be more "incapacitated" than when paralyzed and sedated under general anesthesia undergoing surgery? Obviously, such a person is "vulnerable" and unable to direct care or make medical decisions. The surgeon and hospital are clearly "providing care" for the patient's health? Aren't they uniquely in a position to protect the patient from the very harm that befell him in the analogy? The answer to all these questions is yes.

The term "provide care" is interpreted by Justice Feldman to preclude medical care like that discussed in the analogy because if he were to interpret it any other way, APSA would simply eviscerate the malpractice statute. Justice Feldman holds that such "provided care" in an acute care setting is not actionable under APSA because it defeats the purpose to be served by the patient's care at the hospital. The purpose of an acute care hospital is to treat an acute transitory medical condition that can befall anyone, vulnerable or not before the condition arose; therefore, there is no claim under APSA. In plaintiffs case it was to treat a severe, life threatening pneumonia that caused respiratory failure and multi-organ failure. It was not to treat the cause of Plaintiffs long-term disability - immobility due to bilateral amputation of his legs.

This is the lesson from *McGill.* No other explanation makes sense. The basis for this clear line of demarcation comes directly from the Legislature's intent to create a limited cause of action directed against long-term care givers separate from and different than ordinary medical negligence claims:

> We do not believe interpreting APSA so as to apply to any and every single act of medical malpractice would be consistent with the legislature's obvious intent to protect a class of mostly **elderly** or mentally ill citizens from harm caused by those who have undertaken to give them the care they cannot provide for themselves.

Id. at 529; 57 P.3d at 388. Clearly, the Arizona Supreme Court has interpreted the "provide care" language and determined that care provided in an acute care hospital setting is not included within that provision.

D. Post-McGill Amendment

The Arizona Legislature again amended APSA in response to the Supreme Court's 2003 *McGill* decision expanding APSA relief to certain health care providers. *See* Ariz. Sess. Laws 2003, Ch. 129, § 2. Legislative members noted that the Arizona Supreme Court misinterpreted the Legislature's intent, and clarified that APSA was "passed in response to what was perceived as *nursing home* ***abuses.*** *" See* Minutes of Committee of Health for SB 1010, 2/27/03, comments of Senators Leff and Binder (Exhibit 4); Minutes of Committee on Health for SB 1010, 4/3/03, (comments of Senator Allen). (Exhibit 5)

Consistent with this stated purpose, the Legislature's 2003 Amendment to APSA limited those who could be sued under the APSA. It "expressly prohibit[ed] actions against licensed physicians unless they were employed or retained as the primary care provider by one of the care facilities *enumerated* in the statute." *Brunet v. Murphy,* 212 Ariz. 534, 536; 135 P.3d 714, 716 (App. 2006) (emphasis added). APSA's enumerated facilities are "a nursing care institution, an assisted living center, an assisted living

facility, an assisted living home, an adult day health care facility, a residential care institution, an adult care home, a skilled nursing facility or a nursing facility." *A.R.S. § 46-455(B)(1).* Again, acute-care hospitals like MHMC are omitted from this list. "[T]he amendment was intended to 'provide an exception from civil liability under the Adult Protective Services Act (APSA) for certain health care providers.' *Brunet,* 212 Ariz. at 539; 135 P.3d at 719 (*quoting* Arizona State Senate Fact Sheet for SB 1010 (2003)). Plaintiffs interpretation of this statute would result in the absurdity listed in Illustration #3 *supra* (a consulting specialist is given immunity from APSA for treatment in a nursing home, but could be liable under APSA for treatment in an acute care facility). This is contrary to the stated intention of the Legislature.

Statutes must be interpreted "in such a way as to achieve the general legislative goals that can be adduced from the body of legislation in question." *Zamora,* 185 Ariz. at 275, 915 P.2d at 1230 (citation omitted); *see also Pfeil v. Smith,* 183 Ariz. 63, 64; 900 P.2d 12, 13 (App. 1995) ("The guiding principle of statutory construction is to ascertain and give effect to the legislative intent.").

A.R.S. §46-455(B) was enacted to curb **abuse** in long-term care facilities, and later amended to clarify that its stated and limited focus was *long-term care facilities.* Nowhere in the statute or the APSA's legislative history is there any indication that the Legislature intended to provide an APSA cause of action for anyone admitted to an acute-care hospital. When Arizona's Supreme Court attempted to expand APSA in *McGill,* the Legislature was quick to amend the statute to foreclose that judicially created extension in contravention of the Legislature's intent, and sent the message that APSA can only be the basis for a separate claim if it is against certain medical professionals, but only if they are working in a long-term-care-facility. *See* A.R.S. § 46-455(B)(1)& (2). "Hospital" is not among the facilities included on the list. *Id.*

E. Other plain language of APSA, particularly A.R.S. § 46-455(C), is consistent with the Legislative intent to preclude claims against acute care hospitals.

The Legislature's exclusion of acute-care hospitals from the list of institutions addressed in the statute demonstrates its clear intent to shield acute-care hospitals and their health care providers from the APSA's reach. "It is a fundamental principle of statutory construction that items not placed in a list of exemptions to a general rule are covered by that general rule." *Fund Manager, Pub. Safety Pers. Ret. Sys. v. Arizona Dept. of Admin.,* 151 Ariz. 93, 95; 725 P.2d 1127, 1129 (App. 1986); *see also Burkett v. Mott by Maricopa County Pub. Fiduciary.* 152 Ariz. 476, 478; 733 P.2d 673. 675 (App. 1986). "Under the well-established rule of statutory construction, *'expressio unius est exclusion alterius.'* 'if a statute specifies one exception to a general rule. other exceptions are excluded.' " *Id. (quoting Bushnell v. Superior Court,* 102 Ariz. 309, 311; 428 P.2d 987. 989 (1967)). If the legislature wanted APSA to apply to acute-care hospitals it would have said so; it did not. [4]

Further, A.R.S. §46-455(C) leaves no doubt that acute care hospitals and their care providers are exempt from APSA liability. It states:

> Any person who was the primary provider of medical services to the patient in the last two years before it was recommended that the patient be admitted to one of the facilities list in subsection B, paragraph 1 of this section is exempt from civil liability for damages under this section.

This subsection shields primary providers from civil liability under APSA for their work in all facilities other than the long-term care facilities expressly listed in Subsection (B). Acute care hospitals are not listed in Subsection (B) and therefore, the providers of medical services in acute care hospitals are exempt from APSA civil liability. A contrary interpretation would contradict Subsection (C), and render it meaningless. *See Weitekamp v. Fireman's Fund Ins. Co.,* 147 Ariz. 274, 275-76; 709 P.2d 908, 909-10 (App. 1985) (a "cardinal rule" of statutory interpretation requires that "each word or phrase must be given meaning so that no part is rendered void, superfluous, contradictory or insignificant. If certain portions appear to be in conflict, they must be harmonized, if possible, to give full effect to the statute") (internal citations omitted); *see* also *Epstein v. Indus.*

Comm'n of Arizona, 154 Ariz. 189, 194; 741 P.2d 322. 327 (App. 1987) ("Statutes must be given a sensible construction to avoid an absurd result.").

Plaintiff came to MHMC for medical services he needed due to his life-threatening respiratory affliction. Before this, he lived in his home and was making decisions regarding his life. According to Plaintiff, MHMC was responsible for the care Plaintiff received while he was at MHMC and, thus, MHMC should be considered a primary provider of medical services to Plaintiff while he was at MHMC, under the terms of this statutory section. In that event, MHMC is exempt from APSA pursuant to the terms of A.R.S. § 46-455 (C).

A.R.S. §46-455(C) evidences that the Arizona Legislature intended a bright line test in terms of what triggers the application of APSA and is evidence that the Arizona Legislature never intended for acute care hospitals to be subject to APSA claims for providing acute care. If the statute does not preclude claims against acute care hospitals such as MHMC, and if they are not otherwise outside the scope of APSA, then a doctor (e.g. neurologist) that actually provides the primary care and treatment for a vulnerability-causing condition (e.g. encephalopathy caused by stroke) while that person is a patient in an acute care hospital would not be immune from an APSA claim, but that same physician would be immune from an APSA claim for care and treatment provided to the same person for the same vulnerability-causing condition after that person becomes a resident in a nursing care institution, an assisted living center, an assisted living facility, an assisted living home, an adult day health care facility, a residential care institution, an adult care home, a skilled nursing facility or a nursing facility. A similar absurdity would be an acute care hospital providing no direct care for the vulnerability-causing condition (e.g. treatment for a hip fracture sustained by a demented patient from a nursing facility as a result of a fall) would be subject to an APSA claim if the patient's latent condition surfaces in the hospital. Such construction of this law is absurd, without meaningful basis and is contrary to legislative intent.

Clearly, all primary providers who provide medical care before a person goes to a listed long-term care facility are exempt from APSA claims. It would make absolutely no sense to exempt the people in charge of providing medical care for a person, but not exempt those who were responsible for instituting those orders.

F. The Court should not ignore the *pre-McGill* history of APSA and interpret APSA in an absurd fashion.

As described in detail above, APSA was not designed or intended to be a statute applying to the delivery of medical treatment and medicine in an acute care hospital. As a result, it is no surprise that the Legislature, which did not originally include acute care hospitals within the ambit of APSA and did not then later add acute care hospitals to the list of exempted individual providers who could not be sued unless they held certain positions in listed facilities intended to be covered by APSA. Acute care hospitals were not originally included in APSA; nothing in *McGill* added them to the scope of APSA; and the Legislature had no need to correct the language of APSA as *McGill* did not involve an acute care hospital.

II. PLAINTIFF HAS NOT MET THE THRESHOLD FOR A JURY INSTRUCTION ON APSA

The Court should be aware that Plaintiff has not met a minimum threshold for proceeding with an APSA claim.

A. Plaintiff has not produced evidence that he was a vulnerable or incapacitated adult as defined by the APSA.

Although Plaintiff had bi-lateral amputations upon entering MHMC, he has not produced evidence of his vulnerability and his inability to protect himself. A "Vulnerable Adult" is:

> [A]n individual who is 18 years of age or older and who is unable to protect himself from **abuse**, neglect or exploitation by others because of a physical or mental impairment. Vulnerable adult includes an incapacitated person as defined in section 14-5101.

A.R.S. § 46-451(A)(9).

Plaintiff was not incapacitated person as defined by the statute(s). "Incapacitated" means:

> [A]ny person who is impaired by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, chronic use of drugs, chronic intoxication or other cause, except minority, to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person.

A.R.S. § 14-5101(1).

Plaintiff has produced no evidence of a mental illness, disorder or deficiency. When he arrived in MHMC's ED. he was in respiratory distress but was able to communicate and follow orders from his providers. He signed consent forms for treatment. Although he has limitations, he was able to move. It is not enough to consider he was dependent on nursing staff "for all activities of daily living" because this is true for every hospitalized patient and such a low hurdle would make every hospitalized patient a vulnerable adult for liability purposes. This is not what the Legislature intended or the courts have held.

Second, Plaintiff was being acutely treated for respiratory distress and respiratory failure. Even though it might have inhibited his ability to ambulate, this condition cannot make a person that is being treated in an acute-care hospital a vulnerable adult for the purposes of the APSA. *See McGill,* 203 Ariz. 525; 57 P.3d 384 (2002). If it could, then any patient with a condition that inhibited someone's movement in any way would confer upon the patient the status of vulnerable adult for the purpose of enabling a claim under APSA. Consequently, nearly every hospitalized person over the age of 18 could make an APSA claim for any alleged act of negligence, thereby rendering the Medical Malpractice statute A.R.S. §12-561-63 superfluous. Again, this is not what the legislature intended or what *McGill* held.

B. Plaintiff does not have a claim for "Neglect" under the APSA.

Plaintiff was not neglected at MHMC. The APSA expressly defines "Neglect" as: [A] *pattern* of conduct without the person's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health."

A.R.S. §46-451(A)(7). There is no evidence in the record of a *pattern* of conduct to deprive Plaintiff of necessary food, water, medication, medical services, shelter, cooling, heating, or other services needed to maintain his *minimum* physical or mental health. The record shows just the opposite.

Plaintiff was hospitalized for acute illness that included respiratory failure, congestive heart failure, pneumonia, kidney failure and sepsis. He was brought to MHMC's ED and initially stabilized to the extent possible before being admitted to the ICU. In the ICU, Plaintiff was provided extensive medical treatment and medications for his life threatening illness. His extensive medical chart from his twenty-one (21) day hospitalization shows a pattern of medical care and treatment that included over 1250 interventions. Plaintiff was fed and given nutritional supplements. He was given fluids (IV and oral) throughout his admission. Given the level of care provided, it would be hard to find a period of time when a nurse or physician was not involved with Plaintiff during his 21-day hospitalization at MHMC. Plaintiff has never and cannot possibly establish a pattern of conduct on the part of MHMC that resulted in the deprivation of anything Plaintiff needed to maintain minimum physical or mental health.

C. Plaintiff does not have a claim for "Abuse" under APSA.

APSA expressly defines "**Abuse**" as:

a) Intentional infliction of physical harm;

b) Injury caused by negligent acts or omissions;

c) Unreasonable confinement;

d) Sexual **abuse** or sexual assault.

A.R.S. §46-455(A)(1). To first address subsections (a) (c) and (d), there were no allegations and no evidence anywhere in the record to support an allegation of intentional infliction of physical harm, unreasonable confinement, sexual **abuse**, or sexual assault against Plaintiff. Plaintiff was restrained while a patient in the ICU, but there was permission for the medically necessary restraints to prevent him from pulling out the medication lines that were providing him air, food and medicines. No one intentionally inflicted physical harm upon Plaintiff, and he was not the victim of sexual **abuse** or sexual assault. Plaintiff has not made any of these allegations and, even if he had there is no evidence in the record to support them. MHMC is entitled to judgment as a matter of law on these elements. This leaves Plaintiff with, "Injury caused by negligent *acts* or omissions" as the only avenue under which it might make an APSA based claim.

The Arizona Supreme Court, in *McGill,* analyzed the APSA and its relationship to medical negligence. *McGill,* 203 Ariz. 525; 57 P.3d 384 (2002). Both *McGill* and the Legislature have indicated that APSA does not, as a matter of law, apply to every act of medical negligence, even those involving **elderly** or incapacitated adults.

> We do not believe interpreting APSA so as to apply to any and every single act of medical malpractice would be consistent with the legislature's obvious intent to protect a class of mostly **elderly** or mentally ill citizens from harm caused by those who have undertaken to give them the care they cannot provide for themselves. Consider for a moment the situation of a surgeon who, while operating on a patient, negligently fails to remove an instrument or discover a perforation in the viscera. Such negligence and the resulting injury can afflict anyone, not just the incapacitated, and is completely separate from the unique role of caregiver and incapacitated recipient.

Id., 203 Ariz. at 529-30; 57 P.3d at 388-89. Simply stated, APSA does not apply to cases where the alleged negligence and resulting injury can or could afflict anyone, not just the incapacitated. *McGill* provided further guidelines for the application of the APSA:

> [T]o be actionable **abuse** under APSA, the negligent act or acts (1) must arise from the relationship of caregiver and recipient, (2) must be closely connected to that relationship, (3) must be linked to the service the caregiver undertook because of the recipient's incapacity, and (4) must be related to the problem or problems that caused the incapacity.

Id. at 530; 57 P.3d at 389. In addition, APSA requires that the alleged act or acts of negligence must have caused and proximately caused the claimed injury. *See* A.R.S. §46-451(A)(1)(b) ("Injury caused by negligent acts or omissions."). Plaintiffs APSA claim fails under the *McGill* test for negligence.

Plaintiff alleges only that MHMC was negligent because he was not repositioned frequently enough. None of Plaintiffs allegations of negligence and its supporting evidence. even if taken in a light most favorable to Plaintiff, comes close to the level contemplated by the legislature and further defined and clarified by *McGill* as constituting "**abuse**" under APSA.

First, assuming that an allegedly incomplete medical chart constitutes a breach of the standard of care, such negligence would not be unique to a vulnerable or incapacitated person. The Court can take judicial notice that deficient charting by the nurses is

alleged in almost every medical malpractice case against a hospital. Assuming this would be negligence, it would not constitute **abuse** under the APSA as it fails elements 3 and 4 of the *McGill* test. The same applies to the allegation that Plaintiff was occasionally repositioned on a 3-hour versus 2-hour interval. The evidence is that he was turned and repositioned as much as he could tolerate - he interacted with the nurses to let them know what he could tolerate. This is not unique to an allegedly vulnerable person or an allegedly incapacitated person and therefore, fails the *McGill* test.

Finally, there is no evidence that any of these allegedly negligent acts caused in fact or proximately caused Plaintiffs deep tissue injury. There is no explanation from any expert in this case about how a failure to write a chart note or put a check mark or writing the wrong number on a paper in a chart can cause a deep tissue injury. Plaintiff has produced no expert testimony or medical literature to support any theories of how a charting error, or the 3 hour versus 2 hour repositioning caused Plaintiffs deep tissue injury.

III. CONCLUSION

APSA is a statute that was enacted to address neglect and **abuse** in the long-term care industry. The genesis of the law was the **abuse** of **elder** adults in the long-term adult care industry. None of APSA's multiple iterations mentions acute care hospitals such as MHMC. The notes from the various Legislatures never mention acute-care hospitals such as MHMC. To extend APSA to acute care hospitals would result in numerous lawsuits that do not seek to further the clearly stated Legislative purpose behind APSA. A reasonably independent 64-year old man with numerous medical issues develops an acute life threatening medical condition - pneumonia and respiratory distress. He sat upright barely moving in his bed at home on a non-pressure relieving surface in an anoxic debilitated state. He develops a latent injury (deep tissue) and is then brought to the hospital. There he receives top-notch care during a 21-day hospitalization in the intensive care unit. He has many medical interventions (>1250 over 21 days). His latent condition surfaces after a week - which plaintiff acknowledges is typical of this injury. Then he brings a lawsuit alleging he was **abused** and/or neglected. This is far beyond the **abuse** and neglect of the aged who are denied care that the Legislature intended.

MHMC respectfully asks this Court to follow the Legislature's intent and urges this Court to deny Plaintiffs request for a jury instruction on **Abuse** and Neglect.

DATED this 17th day of June, 2013.

JARDINE, BAKER, HICKMAN & HOUSTON, P.L.L.C.

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Footnotes

1 This matter is presently before the Arizona Court of Appeals Division 1 for two cases entitled, *Wvatt v. Vanguard Health Systems, Inc.,* 1 CA-CV 12-0422, CV2005-030580, and *Kuhfuss v. John C. Lincoln Health Network,* 1 CA-CV 12-0203, CV2010-012450, both of which held that APSA did not apply to the provision of care in an acute care setting.

2 The Legislature has defined "Hospital" separately and differently from long-term care facilities. Ariz. Admin. Code R9-10-201 (49). Hospital is "a class of health care institution that provides. through an organized medical staff, inpatient beds, medical services, and continuous nursing services for the diagnosis and treatment of patients."

3 An important distinction is that persons admitted to long-term care facilities are "residents" consistent with the intent or expectation that the persons in these facilities generally stay for an extended period such that it becomes the person's residence. In contrast. "patients" admitted to acute-care hospitals are never considered to be residents, and hospitalizations for patients is generally short.

4 Each of the long-term care facilities listed in Subsection (B) is carefully defined by statute. *See.* e.g., A.R.S. §§ 36-401(A)(3) (adult day health care facility); 36-401(A)(7) (assisted living center); 36-104(A)(8) & 36-446(2) (assisted living facility); 36-401(A)(9) (assisted living home); 36-401(A)(31) & 36-446(8) (nursing care institution); 36-401(A)(37) (residential care institution).

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